STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF FINANCIAL EXAMINATION

of

ALTIUS HEALTH PLANS, INC.
of

South Jordan, Utah

as of

December 31, 2005

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February 14, 2007

Honorable Alfred W. Gross, Commissioner
Chair, Financial Condition (E) Committee, NAIC
State Corporation Commission
Bureau of Insurance
Commonwealth of Virginia
PO Box 1157
Richmond, Virginia 23218

Honorable D. Ken Michie, Commissioner
Secretary, Western Zone
State of Utah Insurance Department
3110 State Office Building
Salt Lake City, UT 84114

Commissioner:

Pursuant to your instructions and in compliance with statutory requirements, an examination, as of December 31, 2005, has been made of the financial condition and business affairs of:

Altius Health Plans, Inc.
South Jordan, Utah

a stock Health Maintenance Organization (HMO) hereinafter referred to in this report as the Organization, and the following report of examination is respectfully submitted.

SCOPE OF EXAMINATION

Period Covered by Examination

The current examination covers the period from January 1, 2002, through December 31, 2005, including any material transactions and/or events occurring subsequent to the examination date noted during the course of the examination.

Examination Procedure Employed

The examination included a general review and analysis of the Organization's operations, the manner in which its business was conducted, and a determination of its financial condition as of December 31, 2005. The examination was conducted in accordance with generally accepted standards and procedures of regulatory authorities relating to such examinations.

This examination was conducted under the association plan of the National Association of Insurance Commissioners (NAIC) in accordance with the Financial Condition Examiners Handbook. It also incorporated top-down, risk-focused examination techniques.

The initial phase of the examination focused on evaluating the Organization's governance and control environment, as well as business approach, in order to develop an examination plan tailored to the Organization's individual operating profile. A functional activity approach was determined to be appropriate. The following functional areas were selected for examination: Management, Underwriting, Reinsurance, Claims and Investments.

The examination determined the inherent risks associated with each of the functional areas and assessed the residual risk for each of the areas after considering the mitigating factors. Mitigating factors considered were corporate governance and control environment in addition to work performed by external and internal audit functions. Interviews were held with the senior management of the Organization to gain an understanding of the entity's operating profile and control environment. Based on the assessment of residual risk examination procedures were reduced where considered appropriate.

A letter of representation attesting to the Organization's ownership of all assets and to the nonexistence of unrecorded liabilities was signed by and received from the Organization's management.

An independent certified public accounting (CPA) firm was retained to audit the Organization's financial records for the years ended 2002, 2003, 2004, and 2005. Audit reports generated by the firm were made available for the examination's review. The comparative balances contained in the 2003 audit report were accepted in lieu of the 2002 report.

Status of Prior Examination Findings

The previous examination was performed by the Utah Insurance Department as of December 31, 2001. Items of significance noted in the report generated by the previous examination were appropriately addressed during the current examination period unless otherwise noted in the "Summary" section of this report.

HISTORY

General

The Organization was organized and incorporated under the laws of Utah on July 1, 1987, as FHP of Utah, Inc., a wholly owned subsidiary of FHP, Inc. The Organization was certified as an HMO on July 27, 1987, and became federally qualified on October 24, 1995. In March 1997 PacifiCare Health Systems, Inc. (PHSI) acquired control of FHP, Inc. and its subsidiaries. Following the acquisition, PHSI became the ultimate controlling person in the holding company system and the Organization's name was changed to PacifiCare of Utah, Inc.

Effective September 30, 1998, Elan Health Partners LLC (Elan), a Utah limited liability company, acquired all of the issued and outstanding stock of the Organization.

In 1999 the Organization formed a wholly owned subsidiary, Altius Health Administrators Inc. Effective December 16, 1999, the Department licensed Altius Health Administrators Inc. as a Third Party Administrator.

On October 31, 1999, the Organization acquired certain assets and liabilities of Intergroup of Utah, a subsidiary of Foundation Health Plans. The acquisition was accounted for as a purchase.

On September 20, 2001, Croghan & Sipf Healthcare Enterprises, LLC (Croghan & Sipf), a Delaware limited liability company, purchased 50,000 shares of common stock and 2,400,000 shares of preferred stock from the Organization.

On September 1, 2003, Coventry Health Care, Inc. (CHC) purchased 100% of the Organization's preferred and common stock for approximately $41.6 million.

During the examination period the Organization's Articles of Incorporation were changed twice, namely the 2nd and 3rd Amendments of the Article of Amendment and Restatement of the Articles of Incorporation. The 2nd Amendment changed the Organization's common stock from no par value to $1.00 per share par value. The 3rd Amendment eliminated the Series A Preferred Stock as a class of capital stock, provided that the common stock, par value $1.00 per share was the only authorized class of capital stock, and increased the number of authorized shares of common stock from 130,000 to 3,530,000.

Capital Stock

The amended Articles of Amendment and Restatement of the Articles of Incorporation authorized the Organization to issue 3,530,000 shares of $1.00 par value common stock. There were 3,509,000 outstanding shares and all were issued to Coventry Health Care, Inc.

Dividends to Stockholders

The Organization paid a $10,000,000 dividend to its shareholder during 2005 and another $10,000,000 dividend during 2006.

Management

The following persons served as directors of the Organization as of December 31, 2005:

Name	Principal Occupation
Michael D. Bahr Highland, Utah	President Altius Health Plans
Lance R. Davis Alpine, Utah	Vice President and Assistant Treasurer Altius Health Plans
Thomas A. Davis Atlanta, Georgia	President and Chief Executive Officer Coventry Health Care of Georgia
Francis S. Soistman, Jr. Darnestown, Maryland	Executive Vice President – Health Plan Operations Coventry Health Care

Thomas P. McDonough was elected a member of the board of directors by the sole shareholder commencing September 1, 2006. Mr. McDonough's principal occupation was President, Coventry Health Care, Commercial Products Division. Francis S. Soistman resigned from his position as a director on the board of directors, effective October 10, 2006.

The officers of the Organization as of December 31, 2005, were as follows:

Principal Officer	Office
Michael D. Bahr	President/Chief Executive Officer
Lance R. Davis	Vice-President & Assistant Treasurer
Francis S. Soistman, Jr.	Executive Vice-President
Shirley A. Roquemore-Smith	Secretary
John J. Stelben	Treasurer
John J. Ruhlman	Controller
Jonathan D. Weinberg	Assistant Secretary

Subsequent to the acquisition of the Organization by CHC in September 2003, the parent's audit committee functioned as the Organization's audit committee.

Conflict of Interest Procedure

After the acquisition of the Organization, employees became subject to the CHC Compliance and Ethics Program which requires conflict of interest disclosures. Employees are required to take the ethics training on-line within 30 days of being employed and every year thereafter.

Corporate Records

Subsequent to the acquisition of the Organization, actions of the shareholder and board of directors were documented by written consent in lieu of meetings. In general, these records did not adequately document significant corporate events during the examination period.

Investment custodial agreements, under which a majority of the Organization's invested assets were held, were not authorized by a resolution of the board of directors as required by Utah Administrative Code (U.A.C.) Rule R590-178. On December 11, 2006, the board authorized the custodial agreement in effect at that time.

Information provided by the Organization indicates that the members of the board of directors were provided the prior examination report.

Acquisitions, Mergers, Disposals, Dissolutions, and Purchases or Sales through Reinsurance

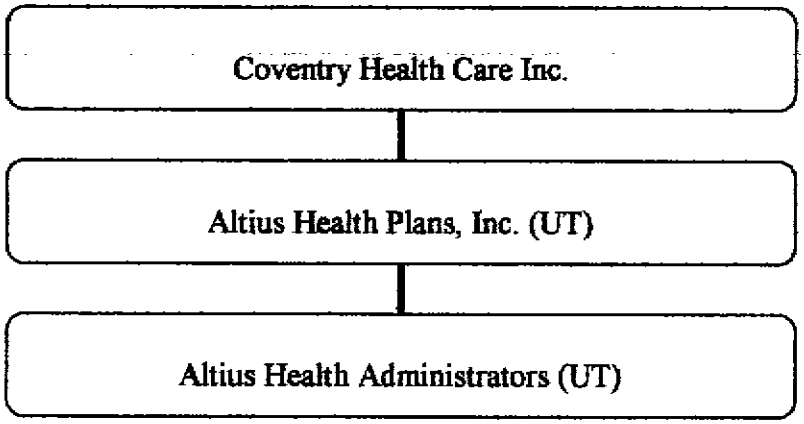
The Organization merged with its 100% subsidiary, Altius Health Administrators, effective March 31, 2006.

Surplus Debentures

On September 1, 2003, Coventry Health Care paid off all of the Organization's outstanding notes as part of its stock purchase agreement.

AFFILIATED COMPANIES

The Organization is wholly owned and controlled by Coventry Health Care, Inc (CHC), a Delaware managed health care company headquartered in Bethesda, Maryland. CHC provides comprehensive health benefits and services to a broad cross section of employer and government funded groups principally in the Midwest, mid-Atlantic and southeastern United States. The following illustrates the Organization's line of governance:



Transactions with Affiliates

Effective September 1, 2003, CHC, provides to the Organization senior management services, advertising, market and public relations services, purchasing services, pharmacy services, corporate and legal services, regulatory compliance and governmental affairs services, accounting services, tax compliance and consulting services, facilities management services, risk management services, human resources consulting and payroll services. CHC is compensated monthly at $2.95 per member per month (pmpm).

Effective June 1, 2004, Coventry Management Services, Inc. (CMS) an affiliate, provides to the Organization general management services, including but not limited to, information system services and consulting and service center services. The Information Systems services include desktop support, application development, data center support, telecommunications support, and network support. The Service Center provides claims processing services, data integrity services, fraud and recovery support, premium billing and collection services, enrollment and eligibility services, member services, and benefit and contract administration. CMS is compensated monthly on a per member per month (pmpm) basis as follows:

	CMS Compensation
Information Systems Services	$3.40 pmpm
Service Center Services	$3.50 pmpm

Effective as amended June 1, 2004, the Organization provides to Altius Health Administrators (AHA) a subsidiary, marketing services such as advertising, sales promotion, and client development. The Organization also provides or arranges for actuarial services for AHA. The Organization is compensated on a pmpm basis limited by the per employee per month (pepm) amounts as follows:

	Altius Compensation	Limitation
Third Party Administration	$1.38 pmpm	$3.96 pepm
Network Lease	$0.40 pmpm	$1.15 pepm

Effective for the tax year ending December 31, 2004, CHC and each of its subsidiaries, including the Organization and AHA, entered into an agreement to set forth the rights and privileges of each party in filing a consolidated federal income tax return. This agreement replaces a substantially similar agreement for the tax year ending December 31, 2003.

Effective October 1, 2003, Coventry Health and Life Insurance Company an affiliate, entered into a reinsurance agreement with the Organization. (REINSURANCE)

FIDELITY BOND AND OTHER INSURANCE

The minimum fidelity coverage suggested by the NAIC for an HMO of the Organization's size and premium volume is not less than $1,000,000. As of the examination date, the Organization participated in fidelity bond coverage of $10,000,000. The Organization also had additional insurance protection for general liability.

PENSION, STOCK OWNERSHIP AND INSURANCE PLANS

Employees were eligible to participate in the Organization's group health plan, CHC 401(k) savings plan, Supplemental Executive Retirement Plan (SERP), and welfare benefit plans. (Pages 53 to 56)

STATUTORY DEPOSITS

As of December 31, 2005, the Organization's statutory deposit requirement was $2,971,305 pursuant to Utah Code Annotated (U.C.A.) § 31A-8-211(1). The Organization maintained a statutory deposit consisting of U.S. Treasury Notes with an aggregate market value of $2,594,565 and aggregate par value of $2,604,000. It was the Organization's standard operating procedure to increase the reserve during the first quarter of each year, after a clear determination of the annual premium revenue for the preceding year. The deposit was increased in March 2006 to bring it into compliance.

INSURANCE PRODUCTS AND RELATED PRACTICES

Policy Forms and Underwriting

A variety of group and individual products were available with various deductibles and co-payments. Products available included:

Group Products

- A "gatekeeper" product, in which members are required to choose a Primary Care Provider (PCP) and get a referral from their PCP in order to see a specialist. Except for emergency room and out-of-area urgent care, members must receive services from participating providers.

- An "open-access" product, in which members are not required to choose a PCP or to receive referrals to see specialists. Except for emergency room and out-of-area urgent care, members must receive services from participating providers.*

- An "open-access" product, in which members are not required to choose a PCP or to receive referrals to see specialists. This product includes a tiered network, with participating providers divided into three different benefit levels that correspond with provider reimbursement arrangements. This allows members to seek care from providers based on varying co-payment/coinsurance amounts. Except for emergency room and out-of-area urgent care, members must receive services from participating providers. The product is optionally available with a fourth benefit level that applies to services received from non-participating providers.

- An "open-access" high deductible health plan product, in which members are not required to choose a PCP or to receive referrals to see specialists. This product meets all necessary internal revenue requirements for compatibility with Health Savings Accounts. Except for emergency room and out-of-area urgent care, members must receive services from participating providers.*

**These products are also available with a non-participating benefit option. Members may use participating providers and receive higher benefits, or they may use non-participating providers and receive lower benefits.*

Individual Products

- An "open-access" product, in which members are not required to choose a PCP or to receive referrals to see specialists. Except for emergency room and out-of-area urgent care, members must receive services from participating providers.

- An "open-access" product, in which members are not required to choose a PCP or to receive referrals to see specialists. This product includes a tiered network, with participating providers divided into three different benefit levels that correspond with provider reimbursement arrangements. This allows members to seek care from providers based on varying co-payment/coinsurance amounts. Except for emergency room and out-of-area urgent care, members must receive services from participating providers. For subscribers with original effective dates prior to October 1, 2004, the product includes a fourth benefit level that applies to services received from non-participating providers.

- An "open-access" high deductible health plan product, in which members are not required to choose a PCP or to receive referrals to see specialists. This product meets all necessary internal revenue requirements for compatibility with Health Savings Accounts. Except for emergency room and out-of-area urgent care, members must receive services from participating providers.

Underwriting guidelines for small groups (2-50) required a statement of health on all eligible employees applying for coverage, including new hires, mid-year and open enrollment. Statements of health for large groups (50+) were only required when medical conditions were identified in the risk evaluation section of the group application. Large groups (100+) were required to submit claims experience and a large claims summary. Underwriting could require supplemental medical questionnaires or other medical information on certain medical conditions.

In general, the Organization's risk retention limits per enrollee were $500,000 plus 10% of all services between $500,000 and $1,000,000 plus amounts in excess of $1,000,000 up to the policy limits. (Refer to REINSURANCE)

Territory and Plan of Operation

As of December 31, 2005, the Organization was licensed as an HMO in Utah and Wyoming and as a managed care organization in Idaho. It was initially licensed in Wyoming and Idaho in 2004. It requested licensing in Nevada as a managed care company during 2005 and the request continued to be in process at year-end. It was also licensed as a third party administrator in Nevada.

As an HMO, the Organization furnished health care services to enrollees through arrangements with providers, in return for prepaid periodic payments. The Organization was obligated to arrange for available and accessible health care. The following counties were included in the Organization's service area:

Beaver	Iron	Sevier
Box Elder	Juab	Summit
Cache	Kane	Tooele
Carbon	Millard	Uintah
Daggett	Morgan	Utah
Davis	Piute	Wasatch
Duchesne	Rich	Washington
Emery (Except Zip Code 84525)	Salt Lake	Wayne
Garfield	San Juan	Weber
Grand (Except Zip Code 84540)	Sanpete	

The Organization markets its products through employees, independent agents and insurance agencies. It maintains an internal sales department composed of 22 sales agents and 4 support staff. In addition, the Organization is contracted with approximately 566 independent sales agents and 288 agencies. (As of December 2005 roughly 296 of these 854 independent sales agents and agencies had business placed with Altius.) Agents and agencies are required to be appointed by the state(s) in which they operate and enter into a "Producer Agreement" with the Organization. Producers agree to perform as set forth in that agreement and as set forth by Organization administrative guidelines, bulletins, directives, and manuals. All new agents are required to undergo training with Altius.

Effective December 31, 2005, the Organization had two provider networks in the Utah market. The Utah Provider Network included 4,277 facility, physician and ancillary providers and the Exclusive Network included 3,691 providers. The Exclusive Network is utilized by one employer group, MountainStar HealthCare. All other Altius commercial, self-funded, and leased business access the Utah Provider Network.

During the current examination period, the Organization expanded its provider network to include all counties in Utah. The primary focus has been on the rural counties and most, if not all, of the hospitals and physicians in those counties participate.

The Organization utilized the following standard agreement types through 2005:

- Altius Ancillary Professional Services Agreement - This contract is used for all types of ancillary providers and for the most part these providers are reimbursed on a fee schedule, a case rate or a % of AWP (Average Wholesale Price).

- Altius Facility Services Agreement is utilized when the Organization is contracting with Free Standing Centers such as Ambulatory Surgical Center, Imaging Centers, Skilled Nursing Centers, Rehabilitation Centers, etc. These provider types are reimbursed through a fee schedule, ASC group rates, case rates or percent of billed methodologies.

- Altius Hospital Services Agreement is utilized for hospital contracting. Our contracted hospital facilities are reimbursed through DRG, per diem, case rates or percent of billed methodologies.

- Altius Hospital Based Provider Services Agreement is offered only to Hospital based providers such as pathologists, radiologists, etc. These providers are normally reimbursed through a fee schedule, case rates and/or percent of billed methodologies.

- Altius Provider Services Agreement is utilized for contracting with physicians and other professional providers such nurse mid-wives, physician assistants, advanced practice register nurse, physical therapists, etc. These providers are reimbursed through fee schedules, case rates, capitation, and/or percent of billed methodologies.

- Altius Vendor Agreement is utilized for companies providing a product such as DME, heart rate monitors, etc. These vendors are reimbursed on a fee schedule.

Effective December 31, 2005, the Organization had developed provider networks in the Idaho and Wyoming markets which were available for sales and marketing activities in the following counties:

IDAHO		**WYOMING**
Ada	Caribou	Lincoln
Boise	Franklin	Sweetwater
Bingham	Oneida	Uinta
Bonneville	Power	

The Idaho Select network is a managed care network which included 12 hospitals, 660 physician and 60 ancillary providers. The Wyoming Provider network included 3 hospitals, 130 physicians and 30 ancillary providers. The Organization has continued its network development activities in both Idaho and Wyoming throughout 2006 and these networks have continued to grow. All of Altius' commercial, self funded and leased business in Idaho and Wyoming access through these networks.

The Organization utilizes the standard Utah provider agreements in Idaho and Wyoming with a few modifications to comply with Idaho and Wyoming state requirements.

Advertising and Sales Material

The Organization's advertising strategy is to get maximum name recognition at the least cost. The main marketing channel is through brokers and agents with very little direct advertising. Advertising with regard to specific insurance policies was not done during the examination period. The Organization participated in the following types of advertising and sales materials:

- Magazine and trade publications
- Name listing in various directories for informational purposes with no advertising
- Sports sponsorship which included very limited television and radio exposure
- Internet banner ads - limited
- Internet links from employer sponsored websites to the Organization's website
- Community activities, such as, presence in pre-show publications and/or use of company logo in show-related activities
- Sales presentation slides
- Employer specific mailers announcing benefit changes and open enrollment times

Treatment of Policyholders

The Organization maintained control over policyholder complaints throughout the examination period. Written procedures to handle written complaints were in place. The Organization maintained a grievance and appeal policy that permitted enrollees the opportunity to request a review of an adverse benefit determination or perceived wrong. The policy allowed enrollees to appeal their cases to a variety of bodies up to and including the Department. The levels of appeal included the following:

- Initial review and research by the Appeals and Grievance Department and/or subcommittee
- Review by an Appeals and Grievance Committee
- Review by the Executive Appeals Committee
- Review by an Independent Reviewer and/or Civil Action
- Submitting an appeal to the Department

A review of paid claims did not indicate a problem with regard to the treatment of policyholders. The following chart identifies the number of written complaints submitted to the Organization and formal complaints submitted to the Department by or on behalf of enrollees and providers regarding payment, non-payment, or denial of services that the complainant believed should have been covered. The formal complaints filed with the Department during the examination period were closed by the date of this examination report. The average number of formal complaints filed with the Department was fourteen.

Period	Claims Paid	Enrollees	Total Appeals	Provider Appeals	Member Appeals	Complaints With Insurance Department	Claim Appeals per Enrollee	Dept Reports per Enrollee
2002	1,297,474	97,519	596	234	362	16	0.37%	0.02%
2003	1,556,855	116,132	1,833	681	1,152	14	0.99%	0.01%
2004	1,926,406	117,984	1,280	335	945	8	0.80%	0.01%
2005	2,301,311	127,659	1,070	163	907	17	0.71%	0.01%

REINSURANCE

As of December 31, 2005, the Organization maintained an HMO Excess Risk Reinsurance Agreement with Coventry Health and Life Insurance Company, an affiliate, which covered plan members enrolled under its commercial HMO and Commercial POS Membership Services Agreements. The agreement provided the Organization 90% proportional coverage for eligible charges in excess of $500,000 per person, per agreement year, not to exceed $1,000,000 per person, per agreement year.

Eligible services include, to the extent they are covered by the Membership Service Agreement applicable to the Member receiving them, all services paid by the Plan, but excluding capitation payment to providers and pharmaceutical costs not paid under the medical benefit.

Eligible charges include the amounts actually paid by the Plan for Eligible Service, but not to exceed the lesser of (1) the amount(s) contracted and (2) the amount(s) negotiated by the Plan with the providers of such services.

ACCOUNTS AND RECORDS

As of December 31, 2005, many functions necessary for the Organization's operations were performed by a parent or affiliate companies under the terms of management agreements. See section of this report entitled AFFILIATED COMPANIES. The Organization's accounting transactions and records were maintained on electronic data processing systems owned and operated by the parent or affiliate companies. The systems were interactive, allowing the Organization on-line access to the information. Its benefit plans were administered on the Coventry Health Care IDX system. Its financial transactions, including general ledger functions, were maintained on PeopleSoft applications.

The following chart identifies the processing functions performed by affiliates at remote locations:

Location	Processing Function
Bethesda, Maryland	Corporate Record Keeping
	Investments
	Legal
	Treasury
Bismarck, North Dakota	Accounts Receivable
	Premium Billing
	Collections
	Claims
	Enrollment
	Group Administration
Cranberry, Pennsylvania	Benefit Administration
	Information Systems
	Recovery Operations
Harrisburg, Pennsylvania	Accounts Receivable
	Premium Billing
	Collections
	Provider Services Administration
Scottsdale, Arizona	Legal

The accounting, actuarial analysis, agent services, appeals, benefit administration, compliance, credentialing, customer service, marketing, pharmacy administration services, provider contracting and relations, quality improvement and reporting, sales, underwriting and utilization management functions are maintained by the Organization in South Jordan, Utah.

The Organization provided the examination with electronic trial balances of general ledger accounts as of December 31 of each year in the examination period. The general ledger account balances were grouped by financial statement account balances. The Organization also provided the examination with electronic general ledger detail reports. This information was used by the examination to review and test significant financial transactions reported in the financial statements.

The Organization is party to an investment accounting services agreement with an external firm under which the firm performs the Organization's investment portfolio accounting and valuation; including: transaction recording and review; cash processing, valuation of assets; regulatory (statutory) reporting; and ad-hoc client reports.

Deficiencies encountered by the examination relating to accounts and records include:

1. The Organization was not a party to the agreement under which a significant majority of its invested assets were held as of December 31, 2005, in violation of U.A.C. Rule R590-178-5. During the Third Quarter 2006, the invested assets were transferred to a new custodian. The Organization was party to the agreement with the new custodian.

2. Section 19 of the above referenced agreement stated "THIS AGREEMENT SHALL BE GOVERNED BY, AND CONSTRUED ACCORDING TO, THE LAWS OF THE STATE OF MARYLAND." An amendment to the agreement was executed during January 2007, providing that the agreement be governed by the laws of the state of Utah for purposes of the assets held for Altius Health Plans.

3. The financial statements do not disclose the method used by the reporting entity to estimate pharmaceutical rebate receivables nor did they report the Pharmacy rebates as invoiced or confirmed in writing; and the Pharmacy rebates collected, as required per the NAIC Statement of Statutory Accounting Procedures (SSAP) No. 84 and the Annual Statement Instructions.

4 Two amendments to the Articles of Incorporation were executed in 2004 but not reported in the 2004 Annual Statement General Interrogatories as required by the 2004 Annual Statement Instructions. The Organization incorrectly reported a change in the articles or bylaws in the 2003 Annual Statement General Interrogatories.

5. The ledgers used to document the Organization's corporate stock were incomplete in regards to the retirement of the capital stock issued and outstanding immediately prior to the Coventry Health Care acquisition and the change in capital stock structure during 2004. An updated stock ledger was provided during the course of the examination.

6. The references to standards adopted by the Actuarial Standards Board of the American Academy of Actuaries and the period of adoption were not consistent with those required in Number 8 of the NAIC Annual Statement Instructions - Health, General section, Actuarial Opinion subsection.

FINANCIAL STATEMENTS

The following financial statements were prepared from the Organization's accounting records and the valuations and determination made during the examination:

BALANCE SHEET as of December 31, 2005

STATEMENT OF REVENUE AND EXPENSES for the Year Ended December 31, 2005

RECONCILIATION OF CAPITAL AND SURPLUS – 2002 through 2005

The accompanying NOTES TO FINANCIAL STATEMENT are an integral part of the financial statements.

ALTIUS HEALTH PLANS
BALANCE SHEET
as of December 31, 2005

ASSETS

	Net Admitted Assets	Notes
Bonds	$ 30,181,488	
Cash and short-term investments	28,106,730	
Investment income due and accrued	380,956	
Uncollected premium	8,076,657	
Current federal income tax recoverable	0	(7)
Net deferred tax asset	1,098,885	(1)
Electronic data processing equipment and software	97,937	
Health care and other amounts receivable	1,156,227	(2)
Total assets	$ 69,098,880	

LIABILITIES, CAPITAL AND SURPLUS

Claims unpaid	$ 21,087,610	(3)
Unpaid claims adjustment expenses	1,056,792	(4)
Aggregate health policy reserves	1,389,283	(5)
Premiums received in advance	518,219	
General expenses due or accrued	3,135,420	(6)
Current federal income tax payable	668,758	(7)
Amounts withheld or retained for the account of others	47,088	
Remittance and items not allocated	91,259	
Amounts due to parent, subsidiaries and affiliates	453,191	
Aggregate write-ins for other liabilities:		
Abandoned property liability	111,570	
Total liabilities	28,559,190	
Common capital stock	3,509,000	
Gross paid in and contributed surplus	36,572,042	
Unassigned funds (surplus)	458,648	
Total capital and surplus	40,539,690	
Total liabilities, capital and surplus	$ 69,098,880	

ALTIUS HEALTH PLANS
STATEMENT OF REVENUE AND EXPENSES
for the Year Ended December 31, 2005

	Amount Total	Notes
Net premium income	$ 287,427,876	(5)
Aggregate write-ins for other health care related revenues:		
Leased network and other income	166,151	
Total revenues	287,594,027	
Medical and Hospital:		
Hospital/medical benefits	133,463,880	(3)
Other professional services	64,599,301	
Prescription drugs	33,782,814	(2)
Subtotal	231,845,995	
Less:		
Net reinsurance recoveries	413,950	
Total medical and hospital	231,432,045	
Claims adjustment expenses	7,061,578	(4)
General administrative expenses	31,870,390	(6)
Increase in reserves for life and accident & health contracts	80,047	
Total underwriting deductions	270,444,060	
Total underwriting gain or (loss)	17,149,967	
Net investment income earned	1,903,810	
Net realized capital gains (losses) less capital gains tax	177,449	
Net investment gains or (losses)	2,081,259	
Net gain or (loss) from agents' or premium balances charged off	(42,910)	
Net income or (loss) before federal income taxes	19,188,316	
Federal and foreign income taxes incurred	3,279,272	(7)
Net income (loss)	$ 15,909,044	

ALTIUS HEALTH PLANS, INC.
RECONCILIATION OF CAPITAL AND SURPLUS
2002 through 2005

	2002*	2003*	2004*	Per Exam 2005	Notes
Capital and surplus prior reporting year	$ 3,833,111	$ 7,518,129	$ 22,182,070	$ 35,548,927	
Net income or (loss)	(1,465,089)	7,478,121	10,537,504	15,909,044	
Change in net deferred income tax	272,138	6,033,994	(4,081,818)	(1,167,760)	(1)
Change in nonadmitted assets	(313,965)	(4,674,627)	5,211,190	249,479	
Change in surplus notes		(11,156,730)			
Capital changes:					
Paid in			3,291,000		
Transferred to surplus	-	(3,400,000)	(17,410,502)		
Surplus adjustments:					
Paid in	-	10,368,762	16,255,334		
Dividends to stockholders				(10,000,000)	
Aggregate write-ins:					
Equity impact of letter of credit	5,000,000	(6,000,000)			
Unrealized gain (loss) on investment with Altius Health Administrators	191,934	(11,292)	(435,851)		
Adjustments to reflect Coventry stock purchase		16,025,713			
Rounding	0				
Net change in capital and surplus	3,685,018	14,663,941	13,366,857	4,990,763	
Capital and surplus end of reporting year	$ 7,518,129	$ 22,182,070	$ 35,548,927	$ 40,539,690	

* Per the regulatory financial statements filed with the Utah Insurance Department.

NOTES TO FINANCIAL STATEMENT

(1) Net deferred tax asset $ 1,098,885

The Organization reported a net deferred tax asset of $1,146,977. Concurrent with examination adjustments to the claims unpaid liability, the asset was decreased and restated by $48,092.

(2) Health care and other amounts receivable $ 1,156,227

The Organization reported a health care and other amounts receivable asset of $1,107,127. Based upon pharmacy claims rebate payments received in 2006, the asset was increased and restated by $49,100.

(3) Claims unpaid $21,087,610

The Organization reported a Claims unpaid liability of $27,622,894. Based upon claims experience through November 2006, the liability was reduced and restated by $6,535,284.

(4) Unpaid claims adjustment expenses $ 1,056,792

The Organization reported an Unpaid claims adjustment expenses liability of $1,144,639. Based upon claims experience through November 2006 the liability was reduced and restated by $87,847.

(5) Aggregate health policy reserves $ 1,389,283

The Organization reported an Aggregate health policy reserves liability of $1,686,687. Based on subsequent experience, the premium deficiency reserve was decreased by $184,890 and the reported liabilities for retrospective agreements and performance guaranty obligations were decreased by $112,514.

(6) General expenses due or accrued $ 3,135,420

The Organization reported a general expenses due or accrued liability of $3,084,077. Concurrent with examination adjustments to the claims unpaid liability, general expenses due or accrued was increased for additional state income taxes payable of $51,343.

(7)	Current federal income tax payable	$ 668,758
	Current federal income tax recoverable	$ 0

The Organization reported a Current federal income tax recoverable asset of $1,722,710. Concurrent with examination adjustments to the claims unpaid liability, the current income tax recoverable asset was offset against additional federal income tax payable of $2,287,377. Federal income taxes payable was also increased by $104,091, concurrent with a decrease in the aggregate health policy reserves.

CAPITAL AND SURPLUS

The Organization's capital and surplus was determined to be $4,478,732 greater than reported in its annual statement as of December 31, 2005. The following schedule identifies the examination changes to specific balance sheet balances:

Description	Statement Dr (Cr)	Per Examination	Surplus Inc. (Dec.)	Notes
Net deferred tax asset	$ 1,146,977	$ 1,098,885	$ (48,092)	(1)
Health care and other amounts receivable	1,107,127	1,156,227	49,100	(2)
Claims unpaid	(27,622,894)	(21,087,610)	6,535,284	(3)
Unpaid claims adjustment expenses	(1,144,639)	(1,056,792)	87,847	(4)
Aggregate health policy reserves	(1,686,687)	(1,389,283)	297,404	(5)
General expenses due or accrued	(3,084,077)	(3,135,420)	(51,343)	(6)
Current federal income tax recoverable	1,722,710	0	(1,722,710)	(7)
Current federal income tax payable	0	(668,758)	(668,758)	(7)
Total examination changes			4,478,732	
Total capital and surplus per Organization			36,060,958	
Total capital and surplus per examination			$ 40,539,690	

The Organization's minimum capital requirement was $100,000 as defined in U.C.A. § 31A-8-209. As defined by U.C.A. § 31A-17 Part 6, the Organization had total adjusted capital of $40,539,690. Its authorized control level risk based capital requirement pursuant to examination was $9,864,495.

SUMMARY OF EXAMINATION FINDINGS

The following is a summary of examination findings and information of special significance:

1. Control of the Organization changed during the examination period. On September 1, 2003, Coventry Health Care, Inc. purchased 100% of the Organization's preferred and common stock for approximately $41,600,000. (HISTORY – General)

2. The Organization's Articles of Incorporation were amended twice during the examination period to change its common stock from no par value to $1.00 per share par value, eliminate its preferred stock and increase the authorized shares of common stock. (HISTORY – General)

3. During 2005 and 2006, the Organization paid an aggregate of $20,000,000 in dividends to Coventry Health Care. (HISTORY - Dividends to Stockholders)

4. In general, the Organization's corporate records did not adequately document significant corporate events during the examination period. The prior report of examination disclosed a similar condition (HISTORY - Corporate Records)

5. Investment custodial agreements, under which a majority of the Organization's invested assets were held, were not authorized by a resolution of the board of directors as required by U.A.C. Rule R590-178. On December 11, 2006, the board of directors authorized the custodial agreement in effect at that time. The prior report of examination disclosed a similar condition. (HISTORY - Corporate Records)

6. The Organization merged with its 100% subsidiary, Altius Health Administrators, effective March 31, 2006. (HISTORY - Acquisitions, Mergers, Disposals, Dissolutions, and Purchases or Sales through Reinsurance)

7. The Organization's statutory deposit requirement was $2,971,305 pursuant to U.C.A. § 31A-8-211(1). It maintained a statutory deposit with an aggregate market value of $2,594,565 and aggregate par value of $2,604,000. It was the Organization's standard operating procedure to adjust the deposit during the first quarter of each year after a clear determination of annual premium for the preceding year. Accordingly, the deposit was increased in March 2006 to bring it into full compliance. (STATUTORY DEPOSITS)

8. The Organization expanded operations into other regulatory jurisdictions during the examination period. It was licensed as an HMO in Wyoming and managed care organization in Idaho during 2004. It requested licensing in Nevada as a

managed care company during 2005. (INSURANCE PRODUCTS AND RELATED PRACTICES – Territory and Plan of Operation)

9. The 2005 Annual Statement contained certain inaccuracies as noted, namely in the General Interrogatories disclosures, and reporting requirements stated in the NAIC Annual Statement Instructions - Health, General section, Actuarial Opinion subsection. In addition, the stock ledgers used to document the Organization's corporate stock were incomplete in regards to the retirement of the capital stock issued and outstanding immediately prior to the Coventry Health Care acquisition and the change in capital stock structure during 2004. An updated stock ledger was provided during the course of the examination. (ACCOUNTS AND RECORDS)

   It is recommend the Company hereafter comply with the provisions of U.C.A. § 31A-2-203 by filing complete and accurate Annual Statements in accordance with the instructions provided.

10. The Organization was not a party to the custodial agreement under which a significant majority of its invested assets were held as of December 31, 2005, in violation of U.A.C. Rule R590-178-5. During the Third Quarter 2006, the invested assets were transferred to a new custodian. The Organization was party to the agreement with the new custodian. Section 19 of the custodial agreement stated "THIS AGREEMENT SHALL BE GOVERNED BY, AND CONSTRUED ACCORDING TO, THE LAWS OF THE STATE OF MARYLAND." An amendment to the agreement was executed during January 2007, providing that the agreement be governed by the laws of the state of Utah for purposes of the assets held for Altius Health Plans. (ACCOUNTS AND RECORDS)

11. The Organization reported a claims unpaid liability of $27,622,894. Based upon the Organization's claims experience through November 2006, the liability was reduced and restated by $6,535,284. (NOTES TO FINANCIAL STATEMENT – (3) Claims Unpaid)

12. The Organization's minimum capital requirement was $100,000 as defined in U.C.A. § 31A-8-209. As defined by U.C.A. § 31A-17 Part 6, the Organization had total adjusted capital of $40,539,690. Its authorized control level risk based capital requirement pursuant to examination was $9,864,495. (CAPITAL AND SURPLUS)

ACKNOWLEDGEMENT

The courteous and responsive cooperation extended by employees of the Organization is acknowledged and appreciated.

Donald Catmull, CFE, Financial Examiner and David Gaines, Financial Analyst, participated in the examination. Colette M. Reddoor, CFE, Assistant Chief Examiner, supervised the examination.

Respectfully Submitted,

John Kay, CFE, CIE
Examiner-In-Charge
Utah Insurance Department